

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 20 Film 242 5-15-59 ams

05646

5671 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USA HOSPITAL ABERDEEN PROVING GROUND, MD		d. STREET ADDRESS 104 B Garden Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROGER	Middle ALLEN	Last ANDERSON	4. DATE OF DEATH Month May Day 5 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 4, 1936	9. AGE (In years lost birthday) 22 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - 2d Lt		10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) South Dakota	
13. FATHER'S NAME Harvey Willard Anderson			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1959		17. INFORMANT Official Army Records	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of brain DUE TO Gunshot wound Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Skull fracture (b) same as a above DUE TO same as a above (c)					
INTERVAL BETWEEN ONSET AND DEATH 17 to 19 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Suicide					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound of the head			
20c. TIME OF INJURY Month, Day, Year 1030 a. m. May 4 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Aberdeen		(County) Harford		(State) Maryland	
21. I certify that I attended the deceased from 1225 May 4, 1959 to 5:30 May 5, 1959 , that I last saw the deceased alive on 3:30 May 5, 1959 , and that death occurred at 5:30 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Lawrence R. Ward, Capt US Army Hospital Aberdeen Proving Gd Md					
DATE SIGNED 5 May 59					
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-7-59		22c. NAME OF CEMETERY OR CREMATORIUM YANKTON	
22d. LOCATION (City, town, or county) (State) YANKTON, SOUTH. DAKOTA					
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Bright, Inc 6009 Harford Road		ADDRESS Arthur L. Krause		24a. REC'D BY REGISTRAR DATE MAY 12 '59	
24b. REGISTRAR'S SIGNATURE					

61. *THE CHIEF CHANGES ARE DRAFTED* *BY THE CHIEF READING* *CLUB*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5652 CERTIFICATE OF DEATH

05647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 15 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dallam Place		32. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
3. NAME OF DECEASED (Type or print) Mary		d. STREET ADDRESS Dallam Place	
4. DATE OF DEATH May 30 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
10c. BIRTHPLACE (State or foreign country) Harford Co., Maryland		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Mc Kee		14. MOTHER'S MAIDEN NAME Wann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mary c. Ayres		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Congestive Heart Failure	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Chr. Cardio-Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs.	
(c)		10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 2, 1953 , to May 30, 1959 , that I last saw the deceased alive on May 30, 1959 , and that death occurred at 6:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard P. Hudson		ADDRESS (Street, city or town, state) Forest Hill, Md.	
PHYSICIAN'S NAME (Type) Willard P. Hudson M.D.		DATE SIGNED May 30, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bel Air		22b. DATE THEREOF June 3, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL St. Ignatius		22d. LOCATION (City, town, or county) Hickory	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		ADDRESS W. Broadway + Williams St. Bel Air, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5672

CERTIFICATE OF DEATH

Reg. Dist. No.

05648

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norrisville		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nicholas		First N.	Middle Ayres
4. DATE OF DEATH May 9 1959		Month May	Day 9
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Shawsville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Ayres		14. MOTHER'S MAIDEN NAME Alice Ann Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 205-22-3834A	
17. INFORMANT Arnold Ayres		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. due to infirmities of old age.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 19, 1959 , to May 9, 1959 , that I last saw the deceased alive on May 7, 1959 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Norman H. Gemini			
ADDRESS (Street, city or town, state) Stevensbourn, Pa. DATE SIGNED May 9, 1959.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/1959	
22c. NAME OF CEMETERY OR CREMATORIAL Ayres Chapel		22d. LOCATION (City, town, or county) (State) White Hall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Fury		24a. REC'D BY REGISTRAR DATE MAY 12 '59	
ADDRESS Jarrettsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05649

3653 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN lb 5 mos.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		32 Bel Air	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Grace		First L.	Middle Bowers
4. DATE OF DEATH May 9 1959		Month May	Day 9
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		9. BIRTHPLACE (State or foreign country) North Carolina	
10. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY U.S.A.,		13. FATHER'S NAME Guy M. Taylor	
14. MOTHER'S MAIDEN NAME Gertrude S. Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. ?		17. INFORMANT Ruth P. Taylor, Bel Air, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESP. FAILURE		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) METASTATIC CARCINOMA.		4 hrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 23 MARCH , 1959, to 2 MAY , 1959, that I last saw the deceased alive on 5 MAY , 1959, and that death occurred at 3:40 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE H.P. Sidwell ADDRESS (Street, city or town, state) 401 Franklin St., Bel Air, Maryland DATE SIGNED May 14 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 12, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Md.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard W. Morris		ADDRESS Abingdon, Maryland.	24a. REC'D BY REGISTRAR DATE MAY 14 '59
		24b. REGISTRAR'S SIGNATURE Arthur & Anna	

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21. DEPARTMENT OF STATE DRAFTS
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5654 CERTIFICATE OF DEATH

05650

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b 21 HRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY BOY		First BABY	Middle BOY
4. DATE OF DEATH MAY 7 1959		Month MAY	Day 7
5. SEX MALE		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 6 1959		9. AGE (In years lost birthday) yrs. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm K. BRENDLE		14. MOTHER'S MAIDEN NAME Evelyn JANE Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Dr. Wm K. BRENDLE, HAVRE DE GRACE, MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO RESPIRATORY FAILURE DUE TO PULMONARY HYALINE MEMBRANE DISEASE PREMATURITY (WEIGHT 5#5¹/₂lb)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. May 7 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —	
(County) —		(State) —	
21. I certify that I attended the deceased from 6 May , 1959, to 7 May , 1959, that I last saw the deceased alive on 7 May , 1959, and that death occurred at 229 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 600 1st Avenue Ave Havre de Grace Md			
DATE SIGNED —			
ACTUAL SIGNATURE R. D. Dornan, M.D.			
PHYSICIAN'S NAME (Type) —			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-8-1959	
22c. NAME OF CEMETERY OR CREMATORIUM ANGEL HILL Cem		22d. LOCATION (City, town, or county) HAVRE DE GRACE MD	
(State) —		(State) —	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell, Havre de Grace Md.		ADDRESS —	
24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 18, Film 275855, am
19 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5673 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bell Air, Md.</i>		c. LENGTH OF STAY IN 1b <i>2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —		24 d. STREET ADDRESS <i>Stone de Grace Alliance</i>	
3. NAME OF DECEASED (Type or print) <i>FATE</i>		First <i>B</i>	Middle <i>R</i>
4. DATE OF DEATH <i>5</i>	Month <i>9</i>	Doy <i>19</i>	Year <i>59</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/10/1920</i>
9. AGE (In years last birthday) <i>88 3/4 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	10c. BIRTHPLACE (State or foreign country) <i>Hawthorneville Ga.</i>
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	12. MOTHER'S MAIDEN NAME <i>Carrie Hill</i>		
13. FATHER'S NAME <i>2 Brown</i>	14. MOTHER'S MAIDEN NAME <i>Carrie Hill</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>W.W. 2</i>	16. SOCIAL SECURITY NO. <i>43-472-444</i>	17. INFORMANT <i>Unknown James Hill Savannah. Ga.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>49 IX</i> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Paul F. Guerin</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>PAUL F. GUERIN</i>	DATE SIGNED <i>5-10-59</i>		
22a. BURIAL/CREMATION: REMOVAL (Specify) <i>5/17/59</i>	22b. DATE THEREOF <i>5/17/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Sylvester</i>	22d. LOCATION (City, town, or county) (State) <i>Sylvester Ga.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington Son. Hanide Grace. Md.</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE MAY 18 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 FilmG243 5/27/59 cap

05652

5674

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY **Harford**
 CITY (If outside corporate limits, write RURAL
OR
end give nearest town)
 TOWN **rural Bel Air**
 HOSPITAL OR
INSTITUTION OR
STREET ADDRESS **Private Home
Graftons Road, Churchville**

MARYLAND
 LENGTH OF STAY
(in this place)
12 days

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland** COUNTY **Harford**

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **rural Jarrettsville**

STREET
ADDRESS
(If rural give location)

rocks, RD

3. NAME OF
DECEASED
(Type or Print)

(First) **Maudie** (Middle) **Elizabeth**

(Last) **Brown**

4. DATE (Month)
OF DEATH **May** (Day) **16, 1959** (Year)

5. SEX

6. COLOR OR
RACE **F** **W**

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) **Married**

8. DATE OF BIRTH

Aug. 22, 1890

9. AGE last birthday
yrs. **68**

IF UNDER 1 YEAR
Months **0** Days **0** Hours **0** Min. **0**

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) **Housewife**

10b. KIND OF BUSINESS
OR INDUSTRY
Home

11. BIRTHPLACE (State or foreign country)

Renick, W. Va.

12. CITIZEN OF WHAT
COUNTRY?

U. S. A.

13. FATHER'S NAME

Harvey Brown

14. MOTHER'S MAIDEN NAME

Fannie Boggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) **NO** (If Yes, give war or dates of service) **-----**

16. SOCIAL SECURITY NO.

233-34-5252

17. INFORMANT & ADDRESS

Isaac M. Brown **rocks, Maryland**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE **(A)**

Cerebral Vascular Accident

INTERVAL BETWEEN
ONSET AND DEATH

24 days

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE DUE TO
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

Hypertensive C-V-D

20 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While Not while
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5/28/50**, 19..... to **5/16/59**, 19....., that I last saw the deceased
alive on **5/16/59**, 19....., and that death occurred at **7:30 AM**, from the causes and on the date stated above.

ADDRESS (Street, city, town, state)

DATE SIGNED

SIGNATURE

R. H. Bartholomew M.D. **Forest Hill, Maryland** **5/16/59**

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

Burial

5/21/1959

**Bel Air
Memorial Gardens**

Bel Air, Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE **MAY 19 '59**

Charles E. Kutz

Jarrettsville *Ind.*

145

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Pages 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

5675 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood</i>		b. COUNTY <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>Route 70</i> 40		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ns Route 70</i>		d. STREET ADDRESS <i>Custom St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Judy G. Burgess</i>	First	Middle	4. DATE OF DEATH <i>May 30 1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 10, 1938</i>
9. AGE (In years, last birthday) <i>20</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS. <i>Days</i>	12. IF UNDER 24 HRS. <i>Hours</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk-Steno.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	11. BIRTHPLACE (State or foreign country) <i>Maine</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William R. Burgess</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Lynch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>007-38-6702</i>	
17. INFORMANT <i>William R. Burgess, Sanford, Maine.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <i>Fracture skull</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>816X</i>			
DUE TO (c) <i>Fracture skull</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident - car with tractor-trailer</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>5-30 59</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>ns Route 70</i>		20f. (City or town) <i>Jaffa Harford</i>	
(County) <i>MD</i>		(State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>Bel Air, MD</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 3, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington, Fairfax, Virginia.</i>	
(State) <i>MD</i>		(State) <i>VA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard R. McCown Jr.</i>		ADDRESS <i>Abingdon, Maryland.</i>	
24a. REC'D BY REGISTRAR <i>DATE JUN 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05654

5655 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		d. STREET ADDRESS Wheel Rd., Rt. # 2, Bel Air, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Enniece		First	Middle	Lost	4. DATE OF DEATH Cheek	Month May	Day 25	Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1873		9. AGE (In years lost birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. MIN. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Ashley Cheek				14. MOTHER'S MAIDEN NAME Ada Johnson				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Cecil Cheek, Wheel Rd., Rt. # 1, Bel Air.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia, terminating DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 443X (b) DUE TO (c) Chronic hypertensive cardio-vascular disease				INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from June , 1939, to May 25 , 1959, that I last saw the deceased alive on May 25 , 1959, and that death occurred at 10:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED Willard P. Hudson, M.D. May 25, 1959										
ACTUAL SIGNATURE Willard P. Hudson		PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May, 27, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Mt., Carmel		22d. LOCATION (City, town, or county) Emmorton, Harford, Md., (State)				
23. FUNERAL DIRECTOR'S SIGNATURE Howard P. Hudson Jr.		ADDRESS Abingdon, Md.,		24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

Finances

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15
FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR	c. LENGTH OF STAY IN 1b 2 YRS								
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 BEL AIR	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) THEODORE EUGENE CORNELL	First THEODORE	Middle EUGENE	Last CORNELL	4. DATE OF DEATH MAY 16	Month MAY	Day 16	Year 1959		
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 12, 1907	9. AGE (In years last birthday) 51	10. IF UNDER 16 YEARS Months 0	Days 0	11. IF UNDER 24 HRS. Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAT. GAS		10b. KIND OF BUSINESS OR INDUSTRY GAS LINES		11. BIRTHPLACE (State or foreign country) WEST VA.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME LAFAYETTE		14. MOTHER'S MAIDEN NAME CORNELL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 233-16-5072			
				17. INFORMANT MRS Ora CORNELL		Address 12 LANGFORD, BEL AIR			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS DUE TO 15MIN INTERVAL BETWEEN ONSET AND DEATH 420.1 Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO DUE TO cause lost.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Philip W. Heuman	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED MAY 16, 1959
EXAMINER'S NAME (Type) PHILIP W. HEUMAN									
22c. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 19, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Willowdale	22d. LOCATION (City, town, or county) Waverley		(State) W. Va				
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Foster Bel Air Md	ADDRESS —	24a. REC'D BY REGISTRAR —	24b. REGISTRAR'S SIGNATURE —	DATE MAY 19 '59					
VS. A15ME 8M 2/57									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be given to the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G-257 2-29-60 25 05656

5657 CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		b. COUNTY Maryland	
c. LENGTH OF STAY IN 1b 7 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Almshouse—Harford County		d. STREET ADDRESS Almshouse—Harford, Md.	
3. NAME OF DECEASED (Type or print) Margaret Elizabeth		First Lee	Middle Curry
4. DATE OF DEATH May 30 1959		Last 87	Month Year Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (State or foreign country) Mo
13. FATHER'S NAME John Wright		14. MOTHER'S MAIDEN NAME Martha Crew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT SAMUEL G. CURRY, HAVRE DE GRACE, Mo.		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Cardio-Vascular Disease DUE TO — (c) —			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —		(County) — (State) —	
21. I certify that I attended the deceased from Oct. 1952 , 19, to May 1959 , 19, that I last saw the deceased alive on May 29, 1959 , 19, and that death occurred at 2 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) —			
ACTUAL SIGNATURE Willard P. Hudson		DATE SIGNED 5/30/59	
PHYSICIAN'S NAME (Type) Willard P. Hudson M.D.		Forest Hill, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-1-1959	22c. NAME OF CEMETERY OR CREMATORIAL ROCK RON CEM.	22d. LOCATION (City, town, or county) HARFORD
23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell, Havre de Grace, Md.		ADDRESS —	24a. REC'D BY REGISTRAR DATE JUN 3 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5658 CERTIFICATE OF DEATH

05657

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Havard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havard, Md.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Grace Rd</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Havard Hospital</i>		d. STREET ADDRESS <i>Grace Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Elmer M. Edwards</i>		First <i>Elmer</i>	Middle <i>M.</i>
4. DATE OF DEATH <i>May 22, 1959</i>		Last <i>Edwards</i>	Month Day Year <i>May 22 1959</i>
5. SEX <i>Male</i>		6. COLOR OR FACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 21, 1871</i>		9. AGE (In years last birthday) yrs. <i>88</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Havard Co. Md. 25, A.</i>	
11. BIRTHPLACE (State or foreign country) <i>Havard Co. Md. 25, A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i>	
13. FATHER'S NAME <i>James H. Bowmar</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Sheridan</i>	
15. HAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give name or date of service) <i>None</i>		16. SOCIAL SECURITY NO. <i>212-14-1496</i>	
17. INFORMANT <i>Elmer Edwards</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocarditis</i> DUE TO (c) <i>Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>May 22, 1959</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 22, 1959</i> to <i>May 22, 1959</i> , that I last saw the deceased alive on <i>May 22, 1959</i> , and that death occurred at <i>Havard, Md.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>F. P. Brodgrass</i> M.D. ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i> DATE SIGNED <i>5/23/59</i>			
22a. BURIAL, Cremation, Removal <i>Burial</i>		22b. DATE THEREOF <i>May 25, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Run</i>		22d. LOCATION (City, town, or county) (State) <i>Havard Cr., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey, Baltimore, Md.</i>		24a. ADDRESS RECD'D BY REGISTRAR DATE <i>May 28 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

40025
MARYLAND STATE GOVERNMENT OF MARYLAND - BALTIMORE CITY
CERTIFICATE OF DEATH

W. J. H. HARRIS, M.D.
2200 N. Charles Street
Baltimore, Maryland
Date of Birth: 10/10/1880
Date of Death: 10/10/1950
Cause of Death: Heart Disease
Place of Death: Home

John W. H. Harris, M.D.
2200 N. Charles Street
Baltimore, Maryland
Date of Birth: 10/10/1880
Date of Death: 10/10/1950
Cause of Death: Heart Disease
Place of Death: Home

John W. H. Harris, M.D.
2200 N. Charles Street
Baltimore, Maryland
Date of Birth: 10/10/1880
Date of Death: 10/10/1950
Cause of Death: Heart Disease
Place of Death: Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G244 7/16/59 cap

5659

CERTIFICATE OF DEATH

Reg. Dist. No.

05658

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 1 HR. 55 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE 24	
3. NAME OF DECEASED (Type or print) MARY		4. DATE OF DEATH Grille MAY 2 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FEDERAL Employee		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE BAEKEY		14. MOTHER'S MAIDEN NAME NELLIE Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Wmkinson Nellie Baekey 953 Chesapeake Drive	
17. INFORMANT Wmkinson Nellie Baekey 953 Chesapeake Drive		Address Hamde Grace Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) ARTERIO SCLEROSIS		YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hamde Grace (County) Hamde Grace (State) MD	
21. I certify that I attended the deceased from 5/29 1959 to 5/2 1959 , that I last saw the deceased alive on 5/2 1959 , and that death occurred at 10 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 209 W. Upton Ave DATE SIGNED Hamde Grace Md	
ACTUAL SIGNATURE Juan Randall Ross M.D.		22d. LOCATION (City, town, or county) Hamde Grace Md (State) MD	
22e. BURIAL, CREMATION, OR MEMORIAL (Specify) Burial 5/7/59		22f. DATE THEREOF May 7 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Juan Randall Ross Hamde Grace Md		24a. REC'D BY REGISTRAR DATE MAY 7 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1
FOR STATE
HEALTH DEPT.
4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tombstone permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKS (RURAL)	c. LENGTH OF STAY IN lb 3 MONTHS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKS (RURAL)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SHARON Rd		d. STREET ADDRESS SHARON RD.					
3. NAME OF DECEASED (Type or print) ALFRED ANDREW GUNTENSPERGER		First ALFRED	Middle ANDREW				
3. NAME OF DECEASED (Type or print) ALFRED ANDREW GUNTENSPERGER	4. DATE OF DEATH MAY 6 1959	Month MAY	Day 6	Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10, 1916	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST	10b. KIND OF BUSINESS OR INDUSTRY EDGEWOOD ARSENAL	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME ALFRED J. GUNTENSPERGER.	14. MOTHER'S MAIDEN NAME MARY D. ROTH.
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. W.W.II	17. INFORMANT MARY	Address GUNTENSPERGER SAME.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) NONE		Coronary Thrombosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) None		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. — p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>Philip W. Heuman</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED MAY 6, 1959
EXAMINER'S NAME (Type) PHILIP W. HEUMAN		

220. BURIAL, CREMATION, OR REMOVAL (Specify) CREMATION	22b. DATE THEREOF 5-9-59	22c. NAME OF CEMETERY OR CREMATORIAL GREENMOUNT CEM.	22d. LOCATION (City, town, or county) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Miller</i>	ADDRESS 901 S. CONKLING ST. BALTIMORE, MD.	24a. REC'D BY REGISTRAR MAY 8 '59	24b. REGISTRAR'S SIGNATURE <i>Charles S. Miller</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05660

5677

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i>darlington</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Anna J. Hopkins</i>		First <i>Anna</i>	Middle <i>J.</i>
4. DATE OF DEATH <i>May 16 1939</i>		Last <i>16</i>	Month <i>May</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept. 25, 1878</i>		9. AGE (In years lost birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house work at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Harford County USA</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Francis J. Hopkins</i>	
14. MOTHER'S MAIDEN NAME <i>Angie Esther</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Mr. & Mrs. Dudley Phillips</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>794X</i> DUE TO <i>old age</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		b) DUE TO <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) <i></i>	
		(State) <i></i>	
21. I certify that I attended the deceased from <i>May 14, 1947</i> , to <i>May 16, 1939</i> , that I last saw the deceased alive on <i>May 12, 1947</i> , and that death occurred at <i>9304 M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Darlington Md</i>	
ACTUAL SIGNATURE <i>Dudley Phillips</i>		DATE SIGNED <i>5/20/59</i>	
PHYSICIAN'S NAME (Type) <i>Dudley Phillips</i>			
22a. BURIAL, CREMATION, REMOVAL (Check) <i>Burial</i>		22b. DATE THEREOF <i>May 19/39</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Darlington Cemetery</i>		22d. LOCATION (City, town, or county) <i>Harford County</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Bailey</i>		24a. REC'D BY REGISTRAR DATE <i>May 28 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>John S. Krause</i>	

1 FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMA3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5660

05661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i> 62 yrs.	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harve de Grace</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Revolution St</i>	d. STREET ADDRESS <i>111 N. Stokes St</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>George Warren Hughes</i>	First <i>George</i>	Middle <i>Warren</i>	Last <i>Hughes</i>	4. DATE OF DEATH <i>May 28</i>	Month <i>May</i>	Doy <i>28</i>	Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/13/1897</i>	9. AGE (In years last birthday) <i>62</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Garage</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	11. BIRTHPLACE (State or foreign country) <i>Harde Grace</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>George W. Hughes Jr.</i>	14. MOTHER'S MAIDEN NAME <i>Laura Anthony</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>	16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Mrs. G. W. Hughes 111 N. Stokes, Harde Grace, Md.</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>			coronary occlusion			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month, Day, Year <i>May 28</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore, Md.</i>	(County) <i>Baltimore Co., Md.</i>	(State) <i>Md.</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Gerald E. Palmer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <i>5-29-59</i>		
EXAMINER'S NAME (Type) <i>Gerald E. Palmer MD</i>	22a. BURIAL OR CREMATION, REMOVAL (Specify) <i>5/31/59</i>	22b. DATE THEREOF <i>5/31/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Chapel Hill</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>	(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Funerary Inc., Harde Grace, Md.</i>	ADDRESS <i>111 N. Stokes St.</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 3 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Greene</i>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5678 CERTIFICATE OF DEATH

05662

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 133 Post Road		d. STREET ADDRESS 133 Post Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEWIS		First HENRY	Middle MARTIN
4. DATE OF DEATH May 18 1959	Month Day Year	5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1883	9. AGE (In years last birthday) yrs. 75	10. IF UNDER 1 YEAR Months Days
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		14. MOTHER'S MAIDEN NAME Cornelia Skee	
13. FATHER'S NAME George Chapman Martin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. L.H. Martin, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
Myocardial Infarction Coronary Occlusion Coronary arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Terminal			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1953 , 19, to 5-18-1959 , that I last saw the deceased alive on 5-18-1959 , and that death occurred at 12:30 AM from the causes and on the date stated above. ACTUAL SIGNATURE Peter P. Rodman, M.D. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 5-18-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/59	22c. NAME OF CEMETERY OR CREMATORIAL Spesutia Cemetery
22d. LOCATION (City, town, or county) Perryman, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Tarring		24a. REC'D BY REGISTRAR DATE MAY 20 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5661 CERTIFICATE OF DEATH

Reg. Dist. No.

05663

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Harford. MARYLAND		Pa. York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Harpre-de-Grace		4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Harford Memorial Hospital		R.D # 2	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Ira Cleveland Masemer		Lost	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan 30. 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS, OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Salesman		Paper Co	Pa.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Masemer, Eli		Ramer, Pa. 10A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No.		176-01-1107	Melvin Masemer, York, Pa. 6 Summit R.D.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concreal Vascular Occlusion</u>		5 days	
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/12</u> , 19 <u>59</u> , to <u>5/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>59</u> , and that death occurred at <u>720 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Dudley Phillips Darlington Md	
ACTUAL SIGNATURE Dudley Phillips		M.D.	
PHYSICIAN'S NAME (Type) Dudley Phillips		DATE SIGNED 5/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/10/59	22c. NAME OF CEMETERY OR Crematory Moses M. Church Cem. East Berlin Adams Co. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Edward P. Baumester		ADDRESS York, Pa.	22d. LOCATION (City, town, or county) (State) 24a. REC'D BY REGISTRAR MAY 11 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5662 CERTIFICATE OF DEATH

Reg. Dist. No.

05664

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) HARFORD MEMORIAL Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill.	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virginia		First MAE	Middle Patrick
Last 6/19 1959		4. DATE OF DEATH MAY 19 1959	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept 14 1897		9. AGE (In years (last birthday) yrs.) 61	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Mo	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John C. McGraw	
14. MOTHER'S MARRIED NAME Nora Boggs		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) Mo	
16. SOCIAL SECURITY NO. Mo 220-14-2928		17. INFORMANT Lonnie Patrick Forest Hill, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 4 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO Coronary thrombosis		4 days	
(c) Arteriosclerotic Cardiovascular Disease 5 yrs.		5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		20f. (City or town) 21. I certify that I attended the deceased from May 12th, 1959, to May 19, 1959, that I last saw the deceased alive on May 19th, 1959, and that death occurred at 135 M, from the causes and on the date stated above. ACTUAL SIGNATURE Edward C. Loo, M.D.	
21. I certify that I attended the deceased from May 12th , 1959, to May 19 , 1959, that I last saw the deceased alive on May 19th , 1959, and that death occurred at 135 M, from the causes and on the date stated above. ACTUAL SIGNATURE Edward C. Loo, M.D.		ADDRESS (Street, city or town, state) 21. ADDRESS (Street, city or town, state) 22. DATE THEREOF REMOVAL (Specify) May 22, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Havre de Grace		22d. LOCATION (City, town, or county) Havre de Grace, Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. D. Bailey		24a. REC'D BY REGISTRAR DATE MAY 22 '59	
ADDRESS H. D. Bailey		24b. REGISTRAR'S SIGNATURE Charles S. Kream	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05665

5663 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanford Grace Md.</i>		c. LENGTH OF STAY IN TB <i>20 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanford Grace</i>	
d. STREET ADDRESS <i>900 S. Market</i>		d. STREET ADDRESS <i>900 S. Market</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Jessie Jackson</i>		First <i>Jessie</i>	Middle <i>Jackson</i>
Last <i>Poist</i>		4. DATE OF DEATH <i>5/13/59</i>	Month Day Year 19
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>8/16/1884</i>
7. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTH PLACE (State or foreign country) <i>Port Deposit, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wesley Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Leora Woodrow</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Elas. S. Poist</i>		Address <i>900 S. Market St. Hanford Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL VASCULAR ACCIDENT</i> DUE TO <i>331X</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>ARTERIOSCLEROSIS</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>			
YEARS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/4</i> , 19 <i>57</i> , to <i>5/12</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5/11</i> , 19 <i>59</i> , and that death occurred at <i>11:05AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James Russell Ross</i>		ADDRESS (Street, city or town, state) <i>200 N. Union Ave</i>	
PHYSICIAN'S NAME (Type) <i>DR. R. W. RANDALL ROSS</i>		DATE SIGNED	
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>5/15/59</i>		22b. DATE THEREOF <i>5/15/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Zion</i>		22d. LOCATION (City, town, or county) <i>Hanford Grace, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son, Hanford Grace, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 18 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur & Krause</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. After this bottom copy has been retained by the hospital or attending physician, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5679

05666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Harford Joppa	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		10 yrs.,	Joppa (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Henry Basye Read		May 21, 1959	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Aug. 31, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,	9. AGE last birthday 72 yrs.
13. FATHER'S NAME Thomas Read		14. MOTHER'S MAIDEN NAME Emma Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 228-18-4867	
17. INFORMANT & ADDRESS Thomas H. Read, Rosedale, Maryland.		18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) Gastric hemorrhage ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Carcinoma of the stomach II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 23, 1959, to May 21, 1959, that I last saw the deceased alive on May 20, 1959, and that death occurred at 1:12 PM, from the causes and on the date stated above. SIGNATURE <i>Willard P. Hudson</i> ADDRESS (Street, city, town, state) DATE SIGNED May 22, 1959			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 24, 1959 NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens LOCATION (City, town, or county) Bel Air, Harford, Maryland. (State)	
24. REC'D BY REGISTRAR DATE MAY 26 '59		REGISTRAR'S SIGNATURE Arthur S. Traas	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howard K. McCormick, Abingdon, Md.			

Fig. 1. *Fig. 1*

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Getting Started

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Franklin, George, Head, Hammond

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Sample size

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5664 CERTIFICATE OF DEATH

05667

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md			
Harford				b. COUNTY		Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Forest Hill		3 days		Forest Hill					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
HARFORD Memorial									
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Letcher	Alexander		Richardson		MAY	17	1959		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
Male	White	WIDOWED <input checked="" type="checkbox"/>	Nov 28-1881	77	0	0	0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Farmer				Virginia		U.S.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John Richardson		Peggy Moxley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
✓				Thomas C Richardson Bel Air Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		3 days							
Cerebral hemorrhage									
DUE TO									
422.1									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.									
(b)									
DUE TO									
(c)									
Chronic Cardio-vascular Disease		?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY		Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m. p. m.				While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
		19							
21. I certify that I attended the deceased from May 12, 1959, to May 17, 1959, that I last saw the deceased alive on May 17, 1959, and that death occurred at 10:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE		Willard P. Hudson M.D.						Forest Hill, Maryland May 18, 1959	
PHYSICIAN'S NAME (Type)		Willard P. Hudson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
Burial		May 19-1959		Bel Air Memorial		Bel Air		Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Joseph Foster		Bel Air Md		DATE MAY 19 '59		Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5665 CERTIFICATE OF DEATH

05668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
HARFORD MARYLAND		Md HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD Grace		c. LENGTH OF STAY IN 1b 45 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE Drive	
3. NAME OF DECEASED (Type or print) Howard		First Grant	Middle Shaefer
4. DATE OF DEATH May		Lost	Month 5
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH APR. 8, 1898		9. AGE (In years (lost birthday) yrs. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS MAN		10b. KIND OF BUSINESS OR INDUSTRY HOME APPLIANCE	11. BIRTHPLACE (State or foreign country) Penns.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME CHARLES T. SHAEFER	
14. MOTHER'S M AIDEN NAME CORA WHITMER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —	
16. SOCIAL SECURITY NO. 17. INFORMANT 178-10-9401 W. PEARL M. Shaefer-Harford Grace, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiac decompensation Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Old rheumatic heart disease (c) and arteriosclerotic cardio- vascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 5th</u> 1959, to <u>May 5th, 1959</u> , that I last saw the deceased alive on <u>May 5th</u> , 1959, and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Edward C. Too, M.D., Harford Grace, Md.	
ACTUAL SIGNATURE Edward C. Too, M.D.		DATE SIGNED 5/5/59	
PHYSICIAN'S NAME (Type) Edward C. Too, M.D.		at 11:30 A.M.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-8-1959	22c. NAME OF CEMETERY OR CREMATORIUM BELAIR MEMORIAL GARDEN - HARFORD Co.
22d. LOCATION (City, town, or county) Md		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell, Harford Grace, Md.		24a. REC'D BY REGISTRAR DATE MAY 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5680 CERTIFICATE OF DEATH

05669

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital Aberdeen Proving Ground, Maryland				d. STREET ADDRESS 7 Grant Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUZAN		First DANIESE	Middle SHAFFER	4. DATE OF DEATH May	Month 10	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 15, 1958	9. AGE (In years lost birthday) yrs. 6	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Refined		10b. KIND OF BUSINESS OR INDUSTRY Refined		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Robert Joseph Shaffer				14. MOTHER'S MAIDEN NAME Georgenia Erickson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address 7 Grant Street Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased intracranial pressure. 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Congenital hydrocephalus. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 9, 1959, to May 10, 1959, that I last saw the deceased alive on May 10, 1959, and that death occurred at 6 A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) J. B. Bryant, Jr., Major, MC U.S.A. Hospital, Aberdeen, Md.							
ACTUAL SIGNATURE <i>J. B. Bryant, Jr.</i> DATE SIGNED <i>5/11/59</i>							
PHYSICIAN'S NAME (Type) J. B. BRYANT, JR., MAJOR, MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/11/1959		22c. NAME OF CEMETERY OR CREMATORIAL Busti Cemetery		22d. LOCATION (City, town, or county) Jamaica New York	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrying Aberdeen, Md.							
ADDRESS				24a. REC'D BY REGISTRAR MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

SC-50 - CERTIFICATE OF DEATH

6-1968-3-5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

5681 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05670

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE		Md		b. COUNTY		Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		31 Aberdeen		d. STREET ADDRESS		P.O. Box #171		e. IS RESIDENCE ON A FARM?			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		P. O. Box #171				d. STREET ADDRESS		P. O. Box #171						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First: <u>Kristie</u> Middle: <u>Lynn</u> Surname: <u>Shivers</u>		Lost		4. DATE OF DEATH		Month: May Day: 27 Year: 59									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years from birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
F		C				Jan 10 1959		— yrs.		Months <u>17</u>		Days <u>17</u>		Hours <u>17</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
Lufant		Lufant		Kansas		USA											
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME															
Frank Allyn Shivers		Elsie Flare Murray															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED?									
No		—		Father: P.O. Box 171 Aberdeen Md.		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		YES <input type="checkbox"/> NO <input type="checkbox"/>									
493X		DUE TO		Pneumonia		Conditions, if any, which gave rise to immediate cause (b)											
DUE TO						(c)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
				Hour		o. m. 19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED							
EXAMINER'S NAME (Type)		Gerald C Palmer															
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)											
Burial		5/29/1959		Mt Calvary Cemetery		Aberdeen Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
John G. Darrow Aberdeen Md.																	
DATE JUN 1 '59																	
9VVVVVVVVXVV																	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 2 years.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5682 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	b. COUNTY <i>Harford</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bell A v.</i>	c. LENGTH OF STAY IN 1b <i>15 Route 1</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Street</i>	d. STREET ADDRESS <i>15 Route 1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Donald Franklin Smith</i>	First <i>M</i>	Middle <i>W</i>	Last <i>Smith</i>	4. DATE OF DEATH Month <i>May</i>	Day <i>23</i>	Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Dec 18 1933</i>	9. AGE (In years last birthday) <i>25</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>	12. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Test Driver</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Albertsen P.C.</i>	11. BIRTHPLACE (State or foreign country) <i>Scarborough Md. USA</i>	12. CITIZEN OF WHAT COUNTRY? <i>Address</i>				
13. FATHER'S NAME <i>Vernon F. Smith</i>	14. MOTHER'S MAIDEN NAME <i>Bethiah Culver</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes. Navy</i>	16. SOCIAL SECURITY NO. <i>212-32-6244</i>	17. INFORMANT <i>Anna Lee Smith Street Md.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Fracture Cervical Vertebra</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Fracture L. Femur</i>		DUE TO (b) <i>Fracture L. Femur</i>	DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Antecedent auto motorcycle type</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 19.) <i>Antecedent auto motorcycle type</i>						
20c. TIME OF INJURY Month, Day, Year Hour p. m. <i>May 23 1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>15 Route 1</i>	20f. (City or town) <i>Bell A v. Harford Md.</i>	(County) <i>Baltimore</i>	(State) <i>Md</i>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Gerald C Palmer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bethel, Md</i>						DATE SIGNED <i>5-23-59</i>
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/26/1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Southern</i>	22d. LOCATION (City, town, or county) <i>Douglas Harford Md.</i>	(State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Rutt</i>	ADDRESS <i>Jarrettsville Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 26 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles E. Rutt</i>				

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5666

05672

CERTIFICATE OF DEATH

Reg. Dist. No. *Bel Air*

1. PLACE OF DEATH

Bel Air

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL
OR
and give nearest town)LENGTH OF STAY
(In this place)

TOWN

Bel Air

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

206 Penna. Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md.

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Bel Air

STREET
ADDRESS

(If rural give location)

206 Penna. Ave.

3. NAME OF
DECEASED(First) *CHARLES* (Middle) *Ryland* (Last) *STEVENS*

(Type or Print)

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

male

white

married

Sept. 6, 1932

26

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

I.B.M. operator

10b. KIND OF BUSINESS
OR INDUSTRY

Glen L. Martin

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles R. Stevens, Sr.

14. MOTHER'S MAIDEN NAME

Laura Maria Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-30-6217

17. INFORMANT & ADDRESS

Maria Harla Stevens, wife, above

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592X IMMEDIATE CAUSE

(A)

*Suffocation from Aspirated Vomit*INTERVAL BETWEEN
ONSET AND DEATH

2 minutes

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

Chronic Glomerular Nephritis

10 YEARS

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

M.

at work

at work

22. I hereby certify that I attended the deceased from.....

alive on.....

4/16, 1959

, and that death occurred at.....

5:40 P.M. from the causes and on the date stated above.

SIGNATURE

Robert Bartholomew

ADDRESS (Street, city, town, state)

DATE SIGNED

M.D. FOREST HILL MARYLAND

5/9/59

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

5/12/59

NAME OF CEMETERY OR CREMATORI

Sacred Heart Cemetery

LOCATION (City, town, or county)

Baltimore, Md.

24. REC'D BY REGISTRAR

MAY 12 '59

REGISTRAR'S SIGNATURE

John J. M. M.

25. FUNERAL DIRECTOR'S SIGNATURE

Charles E. Schimunek

ADDRESS

Funeral Home

3331 Brehms Lane

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1
FOR STATE
HEALTH DEPT.

Item 20 Film 242 5-14-59 a.m. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05673

5667

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9, Film C-212, 5-7-59 md

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Han de Grace 1 1/2 hr</i>		c. LENGTH OF STAY IN 1b <i>XFrom H ill</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Mental Hospital</i>		e. STREET ADDRESS <i>/</i>				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Israel</i>	Last <i>Taylor</i>			
4. DATE OF DEATH	Month <i>MAY</i>	Day <i>2</i>	Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR FACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 16-1879</i>			
9. AGE (In years last birthday) <i>80</i>		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <i>STREET, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>RICHARD Taylor</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA SCARFF</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>MILDRED T. BAILEY</i>				
17. INFORMANT <i>MILDRED T. BAILEY</i>		Address <i>Forest Hill, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Skul</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident, auto-pedestrian type</i>						
20c. TIME OF INJURY Hour <i>2</i> p. m. Month, Day, Year <i>5-2-1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>Street</i>	(County) <i>Harford</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6-2-59</i>		
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		22b. DATE THEREOF <i>BURIAL MAY 5, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>HIGHLAND CEM.</i>		
22d. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22d. LOCATION (City, town, or county) <i>STREET MD.</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Harkins</i>		ADDRESS <i>Delta, Pa.</i>		24a. REC'D BY REGISTRAR <i>DA</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Turner</i>	DATE <i>MAY 5 '59</i>

600301
BY FLOWN IN AIR - IT WAS TO THEM THAT THE STATEMENT WAS MADE
10000 TO STATEMENT OF READING AND WRITING

STATEMENT
THERE STATE

600301

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the burial-transit permit. File Pages 1 and 2 with the State Board of Health. Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05674

Reg. Dist. No.

5668			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)								
a. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND			b. STATE <i>Md</i> b. COUNTY <i>Harford</i>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>								
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <i>Kalmia</i>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kalmia</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Howard A. Thompson</i>			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX <i>M</i>			6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 23 1917</i>	9. AGE (In years last birthday) <i>41</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Deputy Sheriff</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Elwood Thompson</i>			14. MOTHER'S MAIDEN NAME <i>Pearl Kell</i>						Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Not in</i> (Year or unknown) (If not, give war or dates of service) <i>218-07-2654</i>			16. SOCIAL SECURITY NO. <i>218-07-2654</i>						17. INFORMANT <i>Mrs. Howard Thompson</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>			20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						DATE OF DEATH AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i></i>			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
DUE TO (c) <i></i>			22. DATE OF INJURY						23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
24. TIME OF INJURY Hour o. m. p. m. <i>19</i>			25. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>						26. (City or town) <i>Baltimore</i> (County) <i>Harford Co.</i> (State) <i>Md.</i>		
27. ACTUAL SIGNATURE <i>Gerald E. Palmer</i>			28. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <i>5-15-59</i>		
EXAMINER'S NAME (Type) <i>Gerald E. Palmer</i>			29. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
30. BURIAL, CREMATION, REMOVAL (Specify) <i>May 18, 1959</i>			31. DATE THEREOF <i>May 18, 1959</i>						32. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Harford Co., Md.</i>		
33. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i>			34. ADDRESS <i>Baltimore, Md.</i>						35. REC'D BY REGISTRAR <i>May 28 '59</i> 36. REGISTRAR'S SIGNATURE <i>C. E. Hause</i>		
VS. A15ME 5M 2/37											

31. **RECOMMENDED BY A COMMITTEE OF THE STATE DEPARTMENT**
— **MADE TO THE SENATE BY THE SECRETARY OF STATE**—

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [redacted] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5683 CERTIFICATE OF DEATH

05675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN lb 1 day				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) KAREN		First KAREN	Middle MARIE			
4. DATE OF DEATH THYNG		Month May	Day 4			
5. SEX Female		6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3 May 1959		9. AGE (In years last birthday) yrs. 1	10. IF UNDER 1 YEAR Months 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Raymond Boyd Thyng				
14. MOTHER'S MAIDEN NAME Vera Marie Disler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. N/A		17. INFORMANT Father				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Site B-4 Post Trailer Park	20f. (City or town) Aberdeen, Maryland	(County) 	(State)
21. I certify that I attended the deceased from May 3 , 1959, to May 4 , 1959, that I last saw the deceased alive on May 3 , 1959, and that death occurred at 2:35 AM , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>John Z Delp</i>				ADDRESS (Street, city or town, state) USAH, APG, Md.		
PHYSICIAN'S NAME (Type) JOHN Z DELP CAPT MC		DATE SIGNED 4 May 59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/7/1959	22c. NAME OF CEMETERY OR CREMATORIAL Post Cemetery	22d. LOCATION (City, town, or county) Aberdeen Proving Gr. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Darrig</i>		ADDRESS Aberdeen Proving Gr. Md.	24a. REC'D BY REGISTRAR DATE MAY 8 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur & Francis</i>	

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05676

5684

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Hartford		MARYLAND		STATE Maryland COUNTY Hartford	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Rural - Bel Air		45 yrs.		TOWN Rural - Bel Air	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Churchville Road			STREET ADDRESS Churchville Road (If rural give location)		
3. NAME OF DECEASED (Type or Print) BETTY YOUNG			4. DATE OF DEATH May 28 (Year) 1959		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH August 27, 1875	9. AGE last birthday yrs. 83	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming			10b. KIND OF BUSINESS OR INDUSTRY Owner		
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Young			14. MOTHER'S MAIDEN NAME Francis Kirby		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO			16. SOCIAL SECURITY NO. 219-36-1284		
17. INFORMANT & ADDRESS Joseph Y. Umbarger, Bel Air, Md.			18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
422.1 IMMEDIATE CAUSE Cerebro-vascular accident (thrombosis)			24 hours		
ANTECEDENT CAUSE(S) DUE TO			Arterio sclerotic Cardiovascular disease		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			1 year		
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. URINARY Infection; cardiac failure, compensated					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Bel Air (State) Md.	
21d. TIME OF INJURY (Month) May (Day) 28 (Year) 1959 (Hour) 10:50		21e. INJURY OCCURRED M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 18 , 1959, to May 28 , 1959, that I last saw the deceased alive on May 28 , 1959, and that death occurred at 10:50 PM, from the causes and on the date stated above. SIGNATURE Pauline Stoenkler Jr. ADDRESS (Street, city, town, state) 115 Fulford Ave, Bel Air DATE SIGNED 5/28/59					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 31, 1959		NAME OF CEMETERY OR CREMATORIAL Mt. Zion Methodist Cemetery LOCATION (City, town, or county) FOUNTAIN GREEN, Maryland (State) Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Arthur S. Traas		25. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Trotter ADDRESS W. Broadway + Williams St. Bel Air, Maryland	
DATE JUN 2 '59					

37. MONITORING-INFO TO THE STATE CHARTER

STATE MONITORING

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15677

5669 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Harford. MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve-de-Grace		c. LENGTH OF STAY IN 1b 100a.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen.	
3. NAME OF DECEASED (Type or print)		First MICHAEL	Middle VACIK
4. DATE OF DEATH		Month MAY	Day 27
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	8. DATE OF BIRTH 2-29-04
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire-man.		10b. KIND OF BUSINESS OR INDUSTRY A.P.G.	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Vacik	
14. MOTHER'S MAIDEN NAME Mary Miholek		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Novak Funeral Home - 3513 Brighton Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		ACUTE CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 27, 1959</u> , to <u>MAY 27, 1959</u> , that I last saw the deceased alive on <u>MAY 27, 1959</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Philip W. Harman M.D. 307 Hickory, Bel Air, Md. DATE SIGNED <u>MAY 27, 1959</u>			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
22b. DATE THEREOF 5/28/59		22c. NAME OF CEMETERY OR CREMATORIAL Highwood Cemetery	
22d. LOCATION (City, town, or county) Pittsburgh, Pennsylvania		23. FUNERAL DIRECTOR'S SIGNATURE John G. Barron, Aberdeen, Maryland	
24a. ADDRESS John G. Barron, Aberdeen, Maryland		24b. REC'D BY REGISTRAR DATE JUN 1 '59	
24c. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05678

5670 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de Grace		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 ABERDEEN	
3. NAME OF DECEASED (Type or print) John B		d. STREET ADDRESS 1305 D Augusta	
4. DATE OF DEATH Feb. 3-1878		Month MAY	Day 22
5. SEX MALE		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 3-1878	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Barber		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony VETTORINO		14. MOTHER'S MAIDEN NAME Maria Capitelli	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT John P. Vettorino		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 757.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Pulmonary embolism (c) Surgery for Polycystic Disease 88 kidney	
		INTERVAL BETWEEN ONSET AND DEATH few month	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15 , 1957, to May 22 , 1957, that I last saw the deceased alive on May 21 , 1957, and that death occurred at 5 15 M, from the causes and on the date stated above. ACTUAL SIGNATURE John J. Breyent M.D. 610 S Union Ave PHYSICIAN'S NAME (Type)		A ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL OR CREMATION, REMOVAL (Specify) 5/26/59		22b. DATE THEREOF 5/26/59	
22c. NAME OF CEMETERY OR CREMATORIAL St. Johns		22d. LOCATION (City, town, or county) Woodlawn L. O. N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE VIGLIANTE FUNERAL HOME 406 ROGERS AVE		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Traas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

